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Female Reproductive Health History

All Information provided will be kept confidential

Name: _____ Date: _____

Menstruation History

What age did you get your first menses? _____ Yrs

What was the first day of your last menses _____

Is your menstrual cycle? ☐ Regular ☐ Irregular

How long is your cycle? (A typical cycle is 28-30 days) _____ Days

How many days does your period last? _____ Days

Do you bleed or spot in between periods? ☐ Yes ☐ No

How would you describe your flow? ☐ Light ☐ Normal ☐ Heavy

What is the consistency of blood? ☐ Thick ☐ Thin ☐ Watery ☐ Other:

Do you experience blood clots? ☐ Yes ☐ No ☐ Beginning ☐ Middle ☐ End

What is the colour of the blood? ☐ Red ☐ Light Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black

Menstrual Discomfort

Do you experience menstrual pain? ☐ Yes ☐ No ☐ Before ☐ During ☐ After

How long does it last? _____

Does cold or heat relieve the pain? ☐ Yes ☐ No

Does pressure relieve the pain or make it worse? ☐Yes ☐No

Does the pain come and go? ☐ Yes ☐ No

How would you describe the pain? ☐ Cramping ☐ Stabbing ☐ Heavy ☐ Dull

Do pain killers help?

Do you experience any of the following symptoms?

☐ **Bloating** ☐ **Cramps** ☐ **Mood swings** ☐ **Breast tenderness**
☐ **Acne** ☐ **Nausea** ☐ **Loose stools** ☐ **Night sweats**
☐ **Headache** ☐ **Fatigue** ☐**Constipation** ☐ **Sleep disturbances**

Has your period changed since they began? ☐Yes ☐No

In what ways? _____

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Ovulation

Do you ovulate on your own?	☐ Yes	☐ No
Do you know what day you ovulate?	☐ Yes	☐ No
Do you experience pain when you ovulate?	☐ Yes	☐ No
Do you experience breast tenderness around ovulation?	☐Yes	☐No
Do you experience low back pain around ovulation?	☐ Yes	☐ No
Do you currently chart your basal body temperature?	☐ Yes	☐ No
Do you currently have or had in the past a sexually transmitted disease?	☐ Yes	☐ No
Have you had an abnormal pap smear?	☐ Yes	☐ No
Is your sexual energy?	☐ High	☐ Low

Pregnancy

How many times have you been pregnant? _____

How many times have you given birth? _____

How many children do you have and what are their ages? _____

Any D and Cs? ☐ Yes ☐ No

Have you experienced a miscarriage? ☐ Yes ☐ No

If yes, at how many weeks _____

Lab Tests

Test		Results	
FSH	☐ Normal	☐ High	☐ Low
Estrogen	☐ Normal	☐ High	☐ Low
Progesterone	☐ Normal	☐ High	☐ Low
Prolactin	☐ Normal	☐ High	☐ Low
Thyroid	☐ Normal	☐ High	☐ Low
Testosterone	☐ Normal	☐ High	☐ Low
Other:	☐ Normal	☐ High	☐ Low

_____

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General Health History

Have you ever had? ☐PCOS ☐polyps ☐unique uterus shape ☐prolapsed uterus ☐PID ☐endometriosis ☐uterine fibroids ☐pelvis adhesions

Please explain: _____

Do you experience vaginal discharge? ☐white ☐pink ☐red ☐yellow ☐green ☐thin ☐thick ☐sticky ☐ Unusual smell

Do you experience yeast infections? ☐ Yes ☐ No

How frequent? _____

Have you used oral contraceptives? ☐ Yes ☐ No

What type? _____

For how long? _____

When did you stop? _____

How long have you been trying to conceive? _____

Have you or your partner been diagnosed with an issue related to fertility? ☐ Yes ☐ No

What was the diagnosis? _____

Have you been prescribed medication to aid in ovulation? ☐ Yes ☐ No

What medication? _____

For how long _____

Have you had your uterus and fallopian tubes evaluated? ☐Yes ☐No

What ART have you undergone or are you undergoing now? (IUI IVF, ICSI etc.) Please describe:

Month/ Year	Treatment	Location	Results

Additional Comments:

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